Complete Summary

GUIDELINE TITLE

Medication-assisted treatment for opioid addiction in opioid treatment programs: Initial screening, admission procedures, and assessment techniques.

BIBLIOGRAPHIC SOURCE(S)

Initial screening, admission procedures, and assessment techniques. In: Batki SL, Kauffman JF, Marion I, Parrino MW, Woody GE, Center for Substance Abuse Treatment (CSAT). Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. p. 43-61. (Treatment improvement protocol (TIP); no. 43).

GUIDELINE STATUS

This is the current release of the guideline.

COMPLETE SUMMARY CONTENT

SCOPE

DISEASE/CONDITION(S)

Opioid addiction

GUIDELINE CATEGORY

Evaluation
Management
Screening

CLINICAL SPECIALTY

Family Practice
Internal Medicine
Psychiatry
Psychology

INTENDED USERS

Nurses
Physicians
Psychologists/Non-physician Behavioral Health Clinicians
Social Workers
Substance Use Disorders Treatment Providers

GUIDELINE OBJECTIVE(S)

To describe screening and assessment procedures and important considerations that might be made during and shortly after admission to an opioid treatment program, as well as assessment techniques and considerations that are important to ongoing medication-assisted treatment

TARGET POPULATION

Patients with an addiction to opioids who are eligible for medication-assisted treatment programs

INTERVENTIONS AND PRACTICES CONSIDERED

Screening

1. Crisis intervention
2. Eligibility verification
3. Clarification of the treatment alliance
4. Patient education
5. Identification of treatment barriers
6. Screening of emergencies, including assessments of suicidality and violent behavior

Admission to Opioid Treatment Program

1. Timely admission, waiting lists, and referrals
2. Interim maintenance treatment
3. Denial of admission
4. Admission team training
5. Information collection and dissemination

Medical Assessment

1. Determination of opioid addiction and verification of admission eligibility
2. History of nonopioid substance use and treatment
3. Medical history
4. Complete physical examination

5. Laboratory tests including tests for syphilis, hepatitis, tuberculosis (TB), human immunodeficiency virus (HIV), sexually transmitted diseases, and recent drug use
6. Women's health assessment
7. Induction assessment
8. Assessment of patient motivation for change
9. Substance use assessment
10. Cultural and psychosocial assessment
    - History or co-occurring disorders and current mental status
    - Sociodemographic history
    - Assessment of family and cultural background, relationships, and supports
    - History of physical or sexual abuse
    - Assessment of housing status and safety concerns
    - Assessment of criminal history and legal status
    - Assessment of insurance status
    - Employment and military history
    - Assessment of spirituality
    - Assessment of sexual orientation and history
    - Assessment of patients' ability to manage money
    - Assessment of patients' recreational and leisure activities

MAJOR OUTCOMES CONSIDERED

Not stated

METHODOLOGY

METHODS USED TO COLLECT/SELECT EVIDENCE

Hand-searches of Published Literature (Primary Sources)
Hand-searches of Published Literature (Secondary Sources)
Searches of Electronic Databases

DESCRIPTION OF METHODS USED TO COLLECT/SELECT THE EVIDENCE

The literature search involved careful consideration of all relevant clinical and health services research findings, practice experience, and implementation requirements.

NUMBER OF SOURCE DOCUMENTS

Not stated

METHODS USED TO ASSESS THE QUALITY AND STRENGTH OF THE EVIDENCE

Expert Consensus

RATING SCHEME FOR THE STRENGTH OF THE EVIDENCE

Not applicable

METHODS USED TO ANALYZE THE EVIDENCE

Systematic Review

DESCRIPTION OF THE METHODS USED TO ANALYZE THE EVIDENCE

Not stated

METHODS USED TO FORMULATE THE RECOMMENDATIONS

Expert Consensus

DESCRIPTION OF METHODS USED TO FORMULATE THE RECOMMENDATIONS

After selecting a topic, Center for Substance Abuse Treatment (CSAT) invites staff from pertinent Federal agencies and national organizations to be members of a resource panel that recommends specific areas of focus as well as resources that should be considered in developing the content for the Treatment Improvement Protocols (TIP). These recommendations are communicated to a consensus panel composed of experts on the topic who have been nominated by their peers. This consensus panel participates in a series of discussions. The information and recommendations on which they reach consensus form the foundation of the TIP. The members of each consensus panel represent substance abuse treatment programs, hospitals, community health centers, counseling programs, criminal justice and child welfare agencies, and private practitioners. A panel chair (or co-chairs) ensures that the contents of the TIP mirror the results of the group's collaboration.

RATING SCHEME FOR THE STRENGTH OF THE RECOMMENDATIONS

Not applicable

COST ANALYSIS

A formal cost analysis was not performed and published cost analyses were not reviewed.

METHOD OF GUIDELINE VALIDATION

External Peer Review

DESCRIPTION OF METHOD OF GUIDELINE VALIDATION

A large and diverse group of experts closely reviews the draft document. Once the changes recommended by these field reviewers have been incorporated, the Treatment Improvement Protocol (TIP) is prepared for publication, in print and on line.

RECOMMENDATIONS

MAJOR RECOMMENDATIONS

Initial Screening

First Contact

Staff members should be prepared to provide immediate, practical information that helps potential applicants make decisions about medication-assisted treatment for opioid addiction (MAT), including the approximate length of time from first contact to admission, what to expect during the admission process, and types of services offered.

Goals of Initial Screening

The consensus panel recommends the following goals for initial screening:

- Crisis intervention. Identification of and immediate assistance with crisis and emergency situations (see "Screening of Emergencies and Need for Emergency Care" below)
- Eligibility verification. Assurance that an applicant satisfies Federal and State regulations and program criteria for admission to an opioid treatment program (OTP)
- Clarification of the treatment alliance. Explanation of patient and program responsibilities
- Education. Communication of essential information about MAT and OTP operations (e.g., dosing schedules, OTP hours, treatment requirements, addiction as a brain disease) and discussion of the benefits and drawbacks of MAT to help applicants make informed decisions about treatment
- Identification of treatment barriers. Determination of factors that might hinder an applicant's ability to meet treatment requirements, for example, lack of childcare or transportation

Along with these primary goals, initial screening can begin to identify other medical and psychosocial risk factors that could affect treatment, including factors related to mental disorders; legal difficulties; other substance use; and vocational, financial, transportation, and family concerns. Cultural, ethnic, and spiritual factors that affect communication and might affect treatment planning should be noted as early as possible. Staff members should obtain enough information from applicants to accommodate needs arising from any of these factors if necessary.

Screening of Emergencies and Need for Emergency Care

The consensus panel recommends that providers develop medically, legally, and ethically sound policies to address patient emergencies. Emergencies can occur at any time but are most common during induction to MAT and the acute treatment phase. In particular, patients who exhibit symptoms that could jeopardize their or others' safety should be referred immediately for inpatient medical or psychiatric care. If possible, staff members who conduct initial screening and assessment should make appropriate referrals before applicants are admitted to an OTP.

Identifying and assessing emergencies may require staff familiarity with the components of a mental health status examination (see "Psychosocial Assessment" below).

Suicidality

Initial screening and periodic assessments should help determine whether those indicating risks of suicide need additional services (e.g., hospitalization for protection or treatment, outpatient mental treatment, or evaluation for antidepressant medication). See Exhibit 4-1 in the original guideline document for a list of suicide risk factors.

Recommended Responses to Indicators of Suicidality

- Be direct. Talk openly and matter-of-factly about suicide.
- Be willing to listen. Allow expressions of feelings. Accept the feelings.
- Be nonjudgmental. Don't debate whether suicide is right or wrong or feelings are good or bad. Don't lecture on the value of life.
- Get involved. Become available. Show interest and support.
- Don't dare an individual to do it.
- Don't act shocked. This puts distance between the practitioner and the individual.
- Don't be sworn to secrecy. Seek support.
- Offer hope but not glib reassurances that alternatives are available.
- Take action. Remove means, such as guns or stockpiled pills.
- Get help from persons or agencies specializing in crisis intervention and suicide prevention.

Homicidality and Threats of Violence

Threats should be taken seriously. For example, if an individual with knowledge of OTP procedures and schedules makes a threat, patterns of interaction between staff and this individual should be shifted. It might be necessary to change or stagger departure times, implement a buddy system, or use an escort service. Counseling assignments can be changed, or patients can be transferred to another OTP.

The consensus panel recommends that OTP staff members receive training in recognizing and responding to the signs of potential patient violence. OTPs should develop policies and procedures for homicide and other violent situations. The OTP's policy on violence and threats of violence should be explained at the beginning of treatment. Emergency screening and assessment procedures should include the following:

- Asking the patient questions specific to homicidal ideation, including thoughts, plans, gestures, or attempts in the past year; weapons charges; and previous arrests, restraining orders, or other legal procedures related to real or potential violence at home or the workplace.
- Documenting violent incidents and diligent monitoring of these records to assess the nature and magnitude of workplace violence and to quantify risk. When a threat appears imminent, all legal, human resource, employee

assistance, community mental health, and law enforcement resources should be readied to respond immediately.

Admission Procedures and Initial Evaluation

After initial applicant screening, the admission process should be thorough and facilitate timely enrollment in the OTP. The admission process should be designed to engage new patients positively while screening for and assessing problems and needs that might affect MAT interventions.

Timely Admission, Waiting Lists, and Referrals

The longer the delays between first contact, initial screening, and admission and the more appointments required to complete these procedures, the fewer the applicants who actually enter treatment. Prompt, efficient orientation and evaluation contribute to the therapeutic nature of the admission process.

If a program is at capacity, admitting staff should advise applicants immediately of a waiting list and provide one or more referrals to programs that can meet their treatment needs more quickly. A centralized intake process across programs can facilitate the admission process, particularly when applicants must be referred.

If an applicant goes willingly to another program for immediate treatment but prefers admission to the original OTP, the admission process should be completed and the applicant's name added to the waiting list.

Patients who prefer to await treatment at the original site should be added to the waiting list and contacted periodically to determine whether they want to continue waiting or be referred. For individuals who are ineligible, staff should assess the need for other acute services and promptly make appropriate referrals. The consensus panel recommends that each OTP establish criteria to decide which prequalified patients should receive admission priority, especially when a program is near capacity. For example, some programs offer high-priority admission to pregnant women, addicted spouses of current patients, applicants with human immunodeficiency virus (HIV) infection or other serious medical conditions, or former patients who have tapered off maintenance medication but subsequently require renewed treatment.

Interim Maintenance Treatment

For eligible individuals who cannot be admitted to a public or nonprofit program for comprehensive maintenance services within a reasonable geographic area and within 14 days of applying, Federal Regulations provide for interim maintenance treatment, in which medication is administered to patients at an OTP for up to 120 days without formal screening or admission and with only minimal drug testing, assuming the existence of reasonable criteria at the OTP to prioritize admissions.

Denial of Admission

Denial of admission to an OTP should be based on sound clinical practices and the best interests of both the applicant and the OTP. Admission denial should be

considered, for example, if an applicant is threatening or violent. Continuity of care should be considered, and referral to more suitable programs should be the rule. Due process and attention to applicant rights minimize the possibility that decisions to deny admission to an OTP are abusive or arbitrary.

Admission Team

OTPs should have qualified, compassionate, well-trained multidisciplinary teams that efficiently collect applicants' information and histories, evaluate their needs as patients, and orient them to MAT. Team members should be cross-trained in treating addiction and co-occurring disorders. Those conducting admission interviews should be culturally competent, and their interactions with applicants should not be stigmatizing. They also should be able to communicate OTP policies and services and make appropriate referrals.

Information Collection and Dissemination

Collection of patient information and dissemination of program information occur by various methods, such as by telephone; through a receptionist; and through handbooks, information packets, and questionnaires. Medical assessments (e.g., physical examinations, blood work) and psychosocial assessments also are necessary to gather specific types of information. Although collection procedures differ among OTPs, the consensus panel recommends that the following types of information be collected, documented, or communicated to patients:

- Treatment history. An OTP should obtain a new patient's substance abuse treatment history, preferably from previous treatment providers, including information such as use of other substances while in treatment, dates and durations of treatment, patterns of success or failure, and reasons for discharge or dropout. Written consent from a patient is required to obtain information from other programs. (See below for details on other components to include in this history.)
- Orientation to MAT. All patients should receive an orientation to MAT, generally extending over several sessions and including an explanation of treatment methods, options, and requirements and the roles and responsibilities of those involved. Each new patient also should receive a handbook (or other appropriate materials), written at an understandable level in the patient's first language if possible, that includes all relevant program-specific information needed to comply with treatment requirements. Patient orientation should be documented carefully for medical and legal reasons. Documentation should show that patients have been informed of all aspects of the multifaceted MAT process and its information requirements, including (1) the consent to treatment, (2) program recordkeeping and confidentiality requirements (e.g., who has access to records and when, who can divulge information without patient consent), (3) program rules, including patient rights, grievance procedures, and circumstances under which a patient can be discharged involuntarily, and (4) facility safety instructions (e.g., emergency exit routes). OTPs should require patients to sign or initial a form documenting their participation in the orientation process. Also, patients must receive and sign a written consent to treatment form, which is kept on file by the OTP (See Appendix 4-A of the original guideline document for an example of a standard consent form).

- Age of applicant. Persons younger than age 18 must meet specific Federal and State requirements (at this writing, some States prohibit MAT for this group), and an OTP must secure parental or other guardian consent to start adolescents on MAT (see discussion below of exemptions from the Substance Abuse and Mental Health Services Administration's [SAMHSA's] 1-year dependence duration rule).
- Recovery environment. A patient's living environment, including the social network, those living in the residence, and stability of housing, can support or jeopardize treatment.
- Suicide and other emergency risks. (See above.)
- Substances of abuse. A patient's substance abuse history should be recorded, focusing first on opioid use, including severity and age at onset of physical addiction, as well as use patterns over the past year, especially the previous 30 days. A baseline determination of current addiction should meet, to the extent possible, accepted medical criteria. Many people who are opioid addicted use other drugs and alcohol; this multiple substance use has definite implications for treatment outcomes (see section below entitled "Substance Use Assessment"). Therefore, screening and medical assessment also should identify and document nonopioid substance use and determine whether an alternative intervention (e.g., inpatient detoxification) is necessary or possible before an applicant is admitted to the OTP.
- Prescription drug and over-the-counter medication use. All prescription drug and over-the-counter medication use should be identified. Procedures should be in place to determine any instances of misuse, overdose, or addiction, especially for psychiatric or pain medications. The potential for drug interactions, particularly with opioid treatment medications, should be noted.
- Method and level of opioid use. The general frequency, amounts, and routes of opioid use should be recorded. If opioids are injected, the risk of communicable diseases (e.g., HIV/AIDS, hepatitis C, endocarditis) increases. Patient reporting helps providers assess patients' substance addiction and tolerance levels, providing a starting point to prescribe appropriate treatment medication for stabilization).
- Pattern of daily preoccupation with opioids. A patient's daily pattern of opioid abuse should be determined. Regular and frequent use to offset withdrawal is a clear indicator of physiological dependence. In addition, people who are opioid addicted spend increasing amounts of time and energy obtaining, using, and responding to the effects of these drugs.
- Compulsive behaviors. Patients in MAT sometimes have other impulse control disorders. A treatment provider should assess behaviors such as compulsive gambling or sexual behavior to develop a comprehensive perspective on each patient.
- Patient motivation and reasons for seeking treatment. Prospective patients typically present for treatment because they are in withdrawal and want relief. They often are preoccupied with whether and when they can receive medication. Because successful MAT entails not only short-term relief but a steady, long-term commitment, applicants should be asked why they are seeking treatment, why they chose MAT, and whether they fully understand all available treatment options and the nature of MAT. Negative attitudes toward MAT may reduce patient motivation. However, concerns about motivation should not delay admission unless applicants clearly seem ambivalent. In such cases, treatment providers and applicants can discuss the pros and cons of MAT. The consensus panel believes that identifying and addressing concerns about and stressing the benefits of MAT as early as

possible are essential to long-term treatment retention and maintaining patient motivation for treatment.

- Patient personal recovery resources. A patient's comments also can identify his or her recovery resources. These include comments on satisfaction with marital status and living arrangements; use of leisure time; problems with family members, friends, significant others, neighbors, and coworkers; the patient's view of the severity of these problems; insurance status; and employment, vocational, and educational status. Identification of patient strengths (e.g., stable employment, family support, spirituality, strong motivation for recovery) provides a basis for a focused, individualized, and effective treatment plan.
- Scheduling the next appointment. Unless the program can provide assessment and admission on the same day, the next visit should be scheduled for as soon as possible. To facilitate an accurate diagnosis of opioid addiction and prompt administration of the initial dose of medication when other documentation of a patient's condition is unavailable, the applicant should be instructed to report to the OTP while in mild to moderate opioid withdrawal.

Medical Assessment

The results of medical assessment, including toxicology tests, other laboratory results, and psychosocial assessment, usually are reviewed by a program physician and then submitted to the medical director in preparation for pharmacotherapy. Programs should minimize delay in administering the first dose of medication because, in most cases, applicants will present in some degree of opioid withdrawal.

Determination of Opioid Addiction and Verification of Admission Eligibility

Federal Regulations on Eligibility

Federal regulations state that, in general, opioid pharmacotherapy is appropriate for persons who currently are addicted to an opioid drug and became addicted at least 1 year before admission. Documentation of past addiction might include treatment records or a primary care physician's report. When an applicant's status is uncertain, admission decisions should be based on drug test results and patient consultations.

Exemptions from SAMHSA's 1-year Dependence Duration Rule

If appropriate, a program physician can invoke an exception to the 1-year addiction history requirement for patients released from correctional facilities (within 6 months after release), pregnant patients (program physician must certify pregnancy), and previously treated patients (up to 2 years after discharge).

A person younger than 18 must have undergone at least two documented attempts at detoxification or outpatient psychosocial treatment within 12 months to be eligible for maintenance treatment. A parent, a legal guardian, or an adult designated by a relevant State authority must consent in writing for an adolescent

to participate in MAT. Patients younger than 18 should receive age-appropriate treatments, ideally with a separate treatment track (e.g., young adult groups).

Cases of Uncertainty

When absence of a treatment history or withdrawal symptoms creates uncertainty about an applicant's eligibility, OTP staff should ask the applicant for other means of verification, such as criminal records involving use or possession of opioids or knowledge of such use by a probation or parole officer. A notarized statement from a family or clergy member who can attest to an individual's opioid abuse might be feasible.

The consensus panel does not recommend use of a naloxone (Narcan®) challenge test in cases of uncertainty. Physical dependence on opioids can be demonstrated by less drastic measures. For example, a patient can be observed for the effects of withdrawal after he or she has not used a short-acting opioid for 6 to 8 hours. Administering a low dose of methadone and then observing the patient also is appropriate. Administering naloxone, although effective, can initiate severe withdrawal, which the consensus panel believes is unnecessary. It also requires invasive injection, and the effects can disrupt or jeopardize prospects for a sound therapeutic relationship with the patient. The panel recommends that naloxone be reserved to treat opioid overdose emergencies.

History and Extent of Nonopioid Substance Use and Treatment

The extent and level of alcohol and nonopioid drug use and treatment also should be determined, and decisions should be made about whether these disorders can be managed safely during MAT (see "Substance Use Assessment" below).

Medical History

A complete medical history should include organ system diagnoses and treatments and family and psychosocial histories. It should cover chronic or acute medical conditions such as diabetes, liver or renal diseases, sickle cell trait or anemia, and chronic pulmonary disease. Documentation of infectious diseases, including hepatitis, HIV/AIDS, tuberculosis (TB), and sexually transmitted diseases (STDs), is especially important. Staff should note patients' susceptibility to vaccine-preventable illnesses and any allergies and treatments or medications received for other medical conditions. Women's medical histories also should document previous pregnancies; types of delivery; complications; current pregnancy status and involvement with prenatal care; alcohol and drug use, including over-the-counter medications, caffeine, and nicotine, before and during any pregnancies; and incidences of sudden infant death syndrome.

Complete Physical Examination

Each patient must undergo a complete, fully documented physical examination by the program physician, a primary care physician, or an authorized health care professional under the direct supervision of the program physician, before admission to the OTP. The full medical examination, including the results of the serology and other tests, must be documented in the patient's record within 14

days following admission. States may have additional requirements, and OTPs must comply with these requirements. The examination should cover major organ systems and the patient's overall health status and should document indications of infectious diseases; pulmonary, liver, and cardiac abnormalities; dermatologic sequelae of addiction; vital signs; general appearance of head, eyes, ears, nose, throat, chest, abdomen, extremities, and skin; and physical evidence of injection drug use and dependence, as well as the physician's clinical judgment of the extent of physical dependence. Women should receive a pregnancy test and a gynecological examination at the OTP site or by referral to a women's health center. Again, the results of all tests, laboratory work, and other processes related to the initial medical examination are to be contained in the patient's file within 14 days following admission.

Laboratory Tests

Although Federal regulations no longer require OTPs to conduct a full panel of laboratory tests, some States do. The consensus panel recommends that laboratory tests include routine tests for syphilis, hepatitis, tuberculosis (TB), and recent drug use. SAMHSA regulations stipulate "at least eight random drug abuse tests" annually per patient, performed according to accepted OTP practice. Given that some drugs are metabolized extensively and excreted quickly, it is important that analytic procedures provide the highest sensitivity for substances of interest, such as breath testing for alcohol use.

TB Testing

All patients should undergo screening and medical examination for TB every 12 months. Anergy panel tests should be administered to anergic patients (those with diminished reactivity to certain antigens). Patients who are immune system compromised might have a negative purified protein derivative test, even with active infection. A chest x ray or sputum analysis should be done if there is doubt. If a patient has a positive TB test, medical staff should treat the patient accordingly or refer him or her to a primary care clinic for treatment.

Hepatitis Testing

People who inject drugs are at high risk for hepatitis virus infection and should be tested at admission to an OTP.

Any patients whose tests are negative for hepatitis A virus or hepatitis B virus (HBV) infection should be vaccinated for these infections at the OTP or by referral.

The consensus panel strongly recommends that hepatitis C virus (HCV) diagnosis and referral be an integral component of initial MAT assessment. Programs that do not offer onsite HCV antibody testing should provide appropriate referrals.

HIV Testing

OTPs are required to provide adequate medical services, and the program sponsor must be able to document that these services are fully and reasonably available to patients. HIV testing on site or by referral, with pretest and posttest counseling, is

a recommended medical service. OTPs should make HIV testing part of their medical services as recommended by the Centers for Disease Control and Prevention. Medical care and other supportive services can be offered if patients' HIV and HCV statuses are known early in treatment and monitored continuously.

OTPs performing rapid HIV tests should comply with the guidelines provided in SAMHSA's Rapid HIV Testing Initiative (www.samhsa.gov/HIVHep/rhti_factsheet.aspx). As a preliminary positive test, positive results should be confirmed by supplemental HIV testing. In addition, some States have other requirements for laboratory testing in general and HIV testing specifically.

STD Testing

Early testing for STDs in patients receiving MAT usually is a State health requirement. All patients in MAT should receive serologic screening for syphilis and, for women and symptomatic men, genital cultures for gonorrhea and chlamydia. In the early stages of admission and treatment, patients should be educated about the effects of STDs and their correlation with other communicable diseases, such as HIV/AIDS and hepatitis C, to increase patients' knowledge of the ways they can avoid these risks.

Documenting the sexual histories of heterosexual and lesbian, gay, and bisexual (LGB) patients, in terms of timing of sexual encounters and partners, is essential to determine their potential exposure to HCV, HIV, and other STDs, as well as the risk of infection for other sexual partners.

Additional Drug Testing

After initial drug testing, subsequent assessment should include further review of urine, blood, oral fluid, or other drug test results. Ideally, drug tests should be conducted regularly and randomly during treatment.

Women's Health

Women in MAT should receive information on their particular health needs, for example, family planning, gynecological health, and menopause. Women of childbearing age should be counseled on pregnancy testing during admission before making decisions about detoxification. Pregnancy testing, along with onsite access to or referral for family planning services, should be available in all OTPs as part of an overall women's health initiative.

Induction Assessment

A patient should be assessed at least daily during induction for signs of overmedication or undermedication, and dose adjustments should be made accordingly.

Comprehensive Assessment

Completion of induction marks the beginning of stabilization and maintenance treatment and ongoing, comprehensive medical and psychosocial assessment conducted over multiple sessions. This assessment should include, but not be limited to, patient recollections of and attitudes about previous substance abuse treatment; expectations and motivation for treatment; level of support for a substance-free lifestyle; history of physical or sexual abuse; military or combat history; traumatic life events; and the cultural, religious, and spiritual basis for any values and assumptions that might affect treatment. This information should be included in an integrated summary in which data are interpreted, patients' strengths and problems are noted, and a treatment plan is developed that matches each patient to appropriate services.

Data should be collected in a respectful way, taking into consideration a patient's current level of functioning.

SAMHSA regulations require that patients "accepted for treatment at an OTP shall be assessed initially and periodically by qualified personnel to determine the most appropriate combination of services and treatment." Treatment plans should be reviewed and updated, initially every 90 days and, after 1 year, biannually or whenever changes affect a patient's treatment outcomes. Ongoing monitoring should ensure that services are received, interventions work, new problems are identified and documented, and services are adjusted as problems are solved. Patients' views of their progress, as well as the treatment team's assessment of patients' responses to treatment, should be documented in the treatment plan.

Patient Motivation and Readiness for Change

Patient motivation to engage in MAT is a predictor of early retention and is associated with increased participation, positive treatment outcomes, improved social adjustment, and successful treatment referrals.

Starting with initial contact and continuing throughout treatment, assessment should focus on patient motivation for change. OTP staff members help patients move beyond past experiences (e.g., negative relationships with staff, inadequate dosing) by focusing on making a fresh start, letting go of old grievances, and identifying current realities, ambivalence about change, and goals for the future. It often is helpful to enlist recovering patients in motivational enhancement activities.

Substance Use Assessment

As discussed previously, a patient's lifetime substance use and treatment history should be documented thoroughly. The following areas should be assessed:

- Periods of abstinence (e.g., number, duration, circumstances)
- Circumstances or events leading to relapse
- Effects of substance use on physical, psychological, and emotional functioning
- Changing patterns of substance use, withdrawal signs and symptoms, and medical sequelae.

Most patients with histories of multiple substance abuse fall into one of three groups, which should be determined during assessment: those who use multiple substances (1) to experience their psychoactive effects, (2) to self-medicate for clinically evident reasons (e.g., back pain, insomnia, headache, co-occurring disorders), or (3) to compensate for inadequate treatment medication. Multiple substance use should be identified and addressed as soon as possible because of the risk of possible overdose for patients who continue to abuse drugs or alcohol during treatment. Continued substance abuse while in MAT might indicate that another treatment option is more appropriate. A challenge in treating patients who abuse substances for clinically evident reasons is to determine whether the patients are attempting to medicate undiagnosed, misdiagnosed, or undertreated problems. If so, then effectively addressing these related problems may reduce or eliminate continuing drug or alcohol abuse and improve outcomes.

Cultural Assessment

A comprehensive assessment should include patients' values and assumptions; linguistic preferences; attitudes, practices, and beliefs about health and well-being; spirituality and religion; and communication patterns that might originate partly from cultural traditions and heritage. Staff knowledge about diverse groups is important for effective treatment services. Of particular importance are experiences and coping mechanisms related to assimilation and acculturation of groups into mainstream American culture that may affect how they perceive substance abuse and MAT. Gathering pertinent information often must rely on subjective sources (e.g., interviews and questionnaires). Even so, staff members involved in screening and assessment should be cautioned against making value judgments about cultural or ethnic preferences or assumptions about "average" middle-class American values and beliefs.

To the extent possible, patient preferences for staff members who share their cultural identity should be honored. Multilingual educational materials and displays of culturally diverse materials in the OTP help patients feel more at ease when English is not their primary language.

Psychosocial Assessment

The components and objectives of psychosocial assessment also are applicable to patients in MAT. A psychosocial assessment typically identifies the relevant dynamics of patients' lives and functioning both before the onset of illness (e.g., depression, anxiety) and currently. It identifies patients' specific strengths and resources (e.g., employment, supportive family relationships) as a basis for focused, individualized, effective treatment planning.

History of Co-Occurring Disorders and Current Mental Status

Mental status assessments identify the threshold signs of co-occurring disorders and require familiarity with the components of a mental status examination (i.e., general appearance, behaviour, and speech; stream of thought, thought content, and mental capacity; mood and affect; and judgment and insight) as outlined in Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition, Text Revision. A mental status assessment also should look for perceptual disturbances and cognitive dysfunction.

Qualified professionals should train all staff members involved in screening and assessment to recognize signs and symptoms of change in patients' mental status. This training should be ongoing. After reviewing their observations with the program physician, staff members should refer all patients still suspected of having co-occurring disorders for psychiatric evaluation. This evaluation should identify the types of co-occurring disorders and determine how they affect patients' comprehension, cognition, and psychomotor functioning. Persistent neuropsychological problems warrant formal testing to diagnose their type and severity and to guide treatment. Consultations by psychologists or physicians should be requested or referrals made for testing.

Sociodemographic History

Sociodemographic data about an applicant should include employment, educational, legal, military, family, psychiatric, and medical histories, as well as current information, and should be supplemented by documents for identification, such as a driver's license, birth or baptismal certificate, passport, Social Security card, Medicaid card, public assistance card, or identification card from another substance abuse treatment program.

Family and Cultural Background, Relationships, and Supports

The comprehensive assessment should include questions about family relationships and problems, including any history of domestic violence, sexual abuse, and mental disorders (see below). When possible, the assessment should include input from relatives and significant others. Because families with members who abuse substances have problems directly linked to this substance abuse, at least one staff member should be trained in family therapy or in making appropriate referrals for this intervention.

During assessment, program staff should be sensitive to various family types represented in the patient population. For example, programs treating significant numbers of single parents should consider onsite childcare programs.

Any counselor or treatment provider who might confront emergencies related to child or spousal abuse should be trained in how to identify and report these problems.

Staff members should be trained to listen and prepared to hear traumatic stories and handle these situations, for example, by monitoring any intense symptoms and seeking special assistance when necessary. Staff should be able to identify individuals who exhibit certain signs and symptoms associated with abuse (e.g., posttraumatic stress disorder [PTSD]) and provide or coordinate immediate services to address it.

Child abuse. All States require mandatory reporting of child abuse by helping professionals including OTP staff--particularly State-licensed physicians, therapists, nurses, and social workers. Most States require that this reporting be immediate and offer toll-free numbers. Most also require that reports include the name and address of a parent or caretaker, the type of abuse or neglect, and the name of the alleged perpetrator. Failure to report indications of abuse that results in injury to a child can lead to criminal charges, a civil suit, or loss of professional

licensure. Mandated reporters generally are immune from liability for reports made in good faith that later are found to be erroneous.

Staff members who suspect domestic violence should investigate immediately whether a patient's children have been harmed. Inquiries into possible child abuse can occur only after notice of the limitations of confidentiality in MAT has been given to the patient, who must acknowledge receipt of this notice in writing. Patients also must be informed, during orientation and when otherwise applicable, that substance abuse treatment providers are required to notify a children's protective services agency if they suspect child abuse or neglect.

Spousal or partner abuse. Generally, if a patient believes that she or he is in imminent danger from a batterer, the treatment provider should respond to this situation before addressing any others and, if necessary, suspend the screening or assessment interview to do so. He or she should refer a patient to a shelter, legal services, or a domestic violence program if indicated. Providers should be familiar with relevant Federal, State, and local regulations on domestic violence and the legal resources available (e.g., restraining orders, duty to warn, legal obligation to report threats and past crimes, confidentiality).

Recommended Procedures for Identifying and Addressing Domestic Violence*

- Look for physical injuries, especially patterns of untreated injuries to the face, neck, throat, and breasts, which might become apparent during the initial physical examination.
- Pay attention to other indicators: history of relapse or treatment noncompliance; inconsistent explanations for injuries and evasiveness; complications in pregnancy; possible stress- and anxiety-related illnesses and conditions; sad, depressed affect; or talk of suicide.
- Fulfill legal obligations to report suspected child abuse, neglect, and domestic violence.
- Never discuss a patient without the patient's permission; understand which types of subpoenas and warrants require that records be turned over to authorities.
- Convey that there is no justification for battering and that substance abuse is no excuse.
- Contact domestic violence experts when battery has been confirmed.

*State laws may include other requirements

The following methods for exploring potential domestic violence situations can be incorporated into effective assessment tools:

- Always interview patients in private about domestic violence.
- Begin with direct, broad questions and move to more specific ones; inquire how disagreements or conflicts are resolved (e.g., "Do you want to hit [him or her] to make [him or her] see sense?"); ask whether patients have trouble with anger or have done anything when angry that they regret; combine these questions with other types of lifestyle questions.
- Ask about violence by using concrete examples and specific hypothetical situations rather than vague, conceptual questions.

- Display information about domestic violence in public (e.g., waiting room) and private (e.g., restroom) locations.
- Use opportunities during discussions (e.g., comments about marital conflict situations or poor communication with partners) to probe further.
- Obtain as complete a description as possible of the physical, sexual, and psychological violence perpetrated by or on a patient recently; typically, those who commit domestic violence minimize, deny, or otherwise obscure their acts.

History of Physical or Sexual Abuse

Some patients enter an OTP with a history of physical or sexual abuse, which frequently causes additional psychological distress. Information about these types of abuse is important in treatment planning but not always easily accessible using specific assessment tools, especially early in treatment. Some patients with abuse histories might deny their victimization. Many women are less likely to admit abuse to male counselors. Male staff should know when to request a staff change for counseling about physical or sexual abuse. Patients might not be ready to address the problem, think it is unrelated to substance abuse, or be ashamed. Gathering information from them about abuse, therefore, requires extreme care and respect during screening and assessment. Once patients are stabilized and their practical needs are addressed, counseling by qualified treatment providers can focus on this problem.

Peer Relations and Support

The extent of social deterioration, interpersonal loss, and isolation that patients have experienced should be documented thoroughly during screening and assessment. Assessment of a patient's support systems, including past participation in mutual-help groups (e.g., Alcoholics Anonymous, Methadone Anonymous [MA]), is critical to identifying peer support networks that provide positive relationships and enhance treatment outcomes. Some 12-Step groups are ill-informed about MAT and may be unaware of the treatment goals of MAT and less than supportive; in these cases, providers should help patients identify other sources of support (e.g., MA groups) and encourage continued development of some type of peer support network.

Housing Status and Safety Concerns

Based on year 2000 estimates, approximately 10 percent of patients in MAT are homeless or living as transients when admitted to treatment. Moreover, those who are not homeless often live with people who are addicted or in areas where substance use is common. In the opinion of the consensus panel, early intervention to arrange safe, permanent shelter for these patients should be a high priority, and a patient's shelter needs should be ascertained quickly during screening and assessment. OTPs should establish special support services to help patients secure appropriate living arrangements, such as referral agreements with housing agencies or other programs to locate housing that addresses the special needs of homeless patients.

Criminal History and Legal Status

Assessment may involve exploring personal circumstances such as child custody and related obligations. In the consensus panel's experience, many patients ignore legal problems during periods of substance use, but these problems pose a serious threat to recovery. In addition, a patient's arrest record, including age at first arrest, arrest frequency, nature of offenses, criminal involvement during childhood, and life involvement with the criminal justice system, should be clarified.

Insurance Status

Patients' resources to cover treatment costs should be determined during screening and assessment. Often they are uninsured or have not explored their eligibility for payment assistance. The consensus panel believes that OTPs are responsible for helping patients explore payment options so that they have access to a full range of treatment services, including medical care, while ensuring payment to the OTP.

In situations of inadequate funding or patient ineligibility for funds, another source of payment should be identified. OTP staff can assist patients in applying for public assistance or inquiring whether personal insurance will reimburse MAT costs. Counselors can help patients make decisions about involving their insurance companies and address fears that employers will find out about their substance use or that benefits for health care will be denied.

Employment History

Another important component of psychosocial assessment is a patient's employment history. Based on year 2000 estimates, only 20 percent of patients in MAT were employed when admitted to an OTP. Until they are stabilized, employed patients often experience substance-related difficulties at the workplace, including lack of concentration, tardiness and absences, inability to get along with co-workers, on-the-job accidents, and increased claims for workers' compensation. Early identification of these difficulties can help staff and patients create a more effective treatment plan.

Patients who are employed often are reluctant to enter residential treatment or take the time to become stabilized on medication; however, most of these patients would take medical or other leave time if they were hospitalized for other illnesses, and they should be encouraged to take their addiction as seriously. A physician's note recommending time off work for some period might help, but it should be on letterhead that does not reference drug treatment.

Military or Other Service History

A patient's military or other service history can highlight valuable areas in treatment planning. In particular, was military service generally a positive or negative experience? If the former, treatment providers can help patients identify areas of strength of personal achievement, such as the ability to cope under stress, receipt of medals for service accomplishments, and honorable discharge; patients can learn to build on past strengths in current challenging situations and to progress in treatment. If the latter, providers should review patients' negative military experiences, including loss of friends and loved ones, onset of substance

use, war-related injuries, chronic pain, PTSD, and co-occurring disorders (e.g., depression). This information might indicate patterns of behavior that continue to affect recovery.

Patients' military history also might reveal their eligibility for medical and treatment resources through U.S. Department of Veterans Affairs programs and hospitals or social service agencies.

Spirituality

A patient's spirituality can be an important treatment resource, and persons recovering from addiction often experience increased interest in the spiritual aspects of their lives. Staff should assess patients' connections with religious institutions because these institutions often provide a sense of belonging that is valuable in the rehabilitative process.

OTPs should assess spiritual resources adequately. Counselors and other mental health professionals could benefit from training in patient spirituality if it is difficult for them to explore.

Sexual Orientation and History

The assessment and treatment needs of heterosexual and LGB populations are similar and should focus on stopping the substance abuse that interferes with patients' well-being. Assessment of risk factors associated with sexual encounters and partners is essential. What often differs for an LGB population is the importance of assessing patients' sexual or gender orientation concerns, such as their feelings about their sexual orientation. OTP staff should pay strict attention to confidentiality concerns for LGB patients because they may be at increased risk of legal or other actions affecting employment, housing, or child custody. Treatment modalities and programs should be accessible to all groups, and programs providing ancillary services should be sensitive to the special needs of all patients regardless of sexual orientation.

Patients' Ability to Manage Money

Financial status and money management skills should be assessed to help patients understand their fiscal strengths and weaknesses as they become stabilized. Patients often need assistance to adjust to loss of income caused by reduced criminal activity and develop skills that enhance their legitimate earning power.

Recreational and Leisure Activities

Recreational and leisure activities are important in recovery; therefore, assessment should determine any positive activities in which patients have participated before or during periods of substance use. Identifying existing recreational and leisure time preferences and gaining exposure to new ones can be significant steps in developing a recovery-oriented lifestyle.

CLINICAL ALGORITHM(S)

None provided

EVIDENCE SUPPORTING THE RECOMMENDATIONS

TYPE OF EVIDENCE SUPPORTING THE RECOMMENDATIONS

Recommendations are based on a combination of clinical experience and research-based evidence.

BENEFITS/HARMS OF IMPLEMENTING THE GUIDELINE RECOMMENDATIONS

POTENTIAL BENEFITS

Appropriate screening, admission, and assessment of patients undergoing medication-assisted treatment for opioid addiction

POTENTIAL HARMS

Not stated

QUALIFYING STATEMENTS

QUALIFYING STATEMENTS

The opinions expressed herein are the views of the consensus panel members and do not necessarily reflect the official position of Center for Substance Abuse Treatment (CSAT), Substance Abuse and Mental Health Services Administration (SAMHSA), or Department of Health and Human Services (DHHS). No official support of or endorsement by CSAT, SAMHSA, or DHHS for these opinions or for particular instruments, software, or resources described in this document is intended or should be inferred. The guidelines in this document should not be considered substitutes for individualized client care and treatment decisions.

IMPLEMENTATION OF THE GUIDELINE

DESCRIPTION OF IMPLEMENTATION STRATEGY

Chapter 14, Administrative Considerations, in the original guideline document, covers the challenging administrative aspects of managing and staffing the complex and dynamic environment of an opioid treatment program (OTP). Successful treatment outcomes depend on the competence, values, and attitudes of staff members. To develop and retain a stable team of treatment personnel, program administrators must recruit and hire qualified, capable, culturally sensitive individuals; offer competitive salaries and benefit packages; and provide good supervision and ongoing training. Implementing community relations and community education efforts is important for opioid treatment programs. Outreach and educational efforts can dispel misconceptions about medication-assisted treatment for opioid addiction and people in recovery. Finally, the chapter provides a framework for gathering and analyzing program performance data.

Program evaluation contributes to improved treatment services by enabling administrators to base changes in services on evidence of what works. Evaluation also serves as a way to educate and influence policymakers and public and private payers.

Refer to Chapter 14 in the original guideline document for full details (see "Companion Documents" field in this summary).

IMPLEMENTATION TOOLS

Chart Documentation/Checklists/Forms
Quick Reference Guides/Physician Guides

For information about availability, see the "Availability of Companion Documents" and "Patient Resources" fields below.

INSTITUTE OF MEDICINE (IOM) NATIONAL HEALTHCARE QUALITY REPORT CATEGORIES

IOM CARE NEED

Getting Better
Living with Illness

IOM DOMAIN

Effectiveness
Patient-centeredness

IDENTIFYING INFORMATION AND AVAILABILITY

BIBLIOGRAPHIC SOURCE(S)

Initial screening, admission procedures, and assessment techniques. In: Batki SL, Kauffman JF, Marion I, Parrino MW, Woody GE, Center for Substance Abuse Treatment (CSAT). Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. p. 43-61. (Treatment improvement protocol (TIP); no. 43).

ADAPTATION

Not applicable: The guideline was not adapted from another source.

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GUIDELINE COMMITTEE

Treatment Improvement Protocol (TIP) Series 43 Consensus Panel

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FINANCIAL DISCLOSURES/CONFLICTS OF INTEREST

Not stated

GUIDELINE STATUS

This is the current release of the guideline.

GUIDELINE AVAILABILITY

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment (HSTAT) Web site. Also available in Portable Document Format (PDF) from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Web site.

Print copies: Available from the National Clearinghouse for Alcohol and Drug Information (NCADI), P.O. Box 2345, Rockville, MD 20852. Publications may be ordered from NCADI's Web site or by calling (800) 729-6686 (United States only).

AVAILABILITY OF COMPANION DOCUMENTS

The following are available:

- Executive summary. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. xvii-xx. (Treatment improvement protocol (TIP); no. 43).
- Introduction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 1-10. (Treatment improvement protocol (TIP); no. 43).
- History of medication-assisted treatment for opioid addiction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 11-23. (Treatment improvement protocol (TIP); no. 43).
- Pharmacology of medications used to treat opioid addiction. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 25-42. (Treatment improvement protocol (TIP); no. 43).
- Administrative considerations. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 225-240. (Treatment improvement protocol (TIP); no. 43).
- Appendix D: Ethical considerations in MAT. Medication-assisted treatment for opioid addiction in opioid treatment programs. p. 297-304. (Treatment improvement protocol (TIP); no. 43).

Electronic copies: Available from the National Library of Medicine Health Services/Technology Assessment (HSTAT) Web site. Also available in Portable Document Format (PDF) from SAMHSA's National Clearinghouse for Alcohol and Drug Information (NCADI) Web site.

The following are also available:

- Knowledge Application Program. KAP keys for clinicians. Based on TIP 43: Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. 20 p. Electronic copies: Available in Portable Document Format (PDF) from the SAMHSA Web site.
- Quick guide for clinicians. Based on TIP 43: Medication-assisted treatment for opioid addiction in opioid treatment programs. Rockville (MD): Substance Abuse and Mental Health Services Administration (SAMHSA); 2005. 39 p. Electronic copies: Available in Portable Document Format (PDF) from the SAMHSA Web site.

Additionally, an example of Standard Consent to Opioid Maintenance Treatment form can be found in Appendix 4-A of the original guideline document.

PATIENT RESOURCES

None available

NGC STATUS

This NGC summary was completed by ECRI on December 21, 2005. The information was verified by the guideline developer on January 23, 2006.

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